Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETER G FOOX
PO BOX 8795
TYLER TX 75711

Respondent Name
NATIONAL FIRE INSURANCE CO OF HARTFORD

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-1122-01

MFDR Date Received
JANUARY 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We sent the required documentation via fax (verifiable) No payment and per appropriate rules payment should have been made within 45 days of receipt of this claim. When called about it we were told that they will not process bills via fax and in fact have written to me to explain their requirement for billing (see attached). I am told to send the documentation to one address and the invoice to another. This is unacceptable to me and I believe the Division does permit the use of Fax transmission services. If we do not send it this way then all bills would need to be sent via certified mail, because Insurance carrier's have in the past denied receiving it in the mail and hide behind the rule of 95 days and then it's stale. (That is a subject for another day)."

Requestor's Supplemental Position Summary: "I received a phone call from attorney Brian Judis explaining that payment was made for the EMG/NCV studies in the amount of $464.84 for billed amount of $1641.00. I did inform him that would not be acceptable and that they needed to pay according Fee Schedule. He informed me that I would need to prove how much is to be paid."

Amount in Dispute: $1,651.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 5, 2013: "Carrier submits the attached Payment History indicting [sic] that a payment of $464.84 was issued to and cashed by Gerald Peter Foox, MD. Carrier respectfully requests that this matter be dismissed as HCP has received payment."

Respondent's Position Summary dated March 7, 2013: "Carrier submits the attached EOR indicating an additional amount of $421.26. Once this payment has been processed, the total amount paid for this disputed DOS is $886.10. Carrier respectfully requests that this matter be dismissed upon HCP's receipt of this additional payment."

Responses Submitted By: Law Offices of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2012	CPT Code 95903-59 (X4)	$700.00	$0.00
	CPT Code 95904-59 (X2)	$128.00	$42.17
	CPT Code 95934-50 (X1)	$410.00	$0.00
	CPT Code 95861 (X1)	$328.44	$0.00
	CPT Code 95869 (X1)	$163.00	$101.73
TOTAL		$1,651.00	$143.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - 198-Precertification/authorization exceeded.
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - MT12-Diagnosis Code indicates severe injury.
   - M26-Procedure indicates a moderate or severe injury or illness.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - MA04-Number of Occurrences on authorization records has been exceeded.
   - M445-Original Fee Schedule value has been increased according to the state guidelines.
   - U863-The electromyography value is included in the reimbursement value of the other extremity procedure.
   - Z989-Payment of $464.84 was previously issued for this claim. The payment should have been $886.10.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to additional reimbursement for CPT codes 95903, 95904, 95934, 95961, 95969?

Findings

1. A review of the submitted explanation of benefits finds that the respondent initially raised the issue of lack of preauthorization for the disputed services. The Division finds that upon reconsideration, the denial was not maintained and the respondent has paid $886.10 for the disputed services.
2. The issue in dispute is whether the requestor is due additional reimbursement for the disputed services.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

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To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75702, which is located in Tyler, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Rest of Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality Rest of Texas	Maximum Allowable	Respondent Paid	Due
95903	(54.86/34.0376) x $70.26 for 4 Units	$452.96	$452.96	$0.00
95904	(54.86/34.0376) x $52.79 for 2 Units	$170.17	$128.00	$42.17
95934	(54.86/34.0376) x $57.64 for 1 Unit	$92.90	$92.91	$0.00
95861	(54.86/34.0376) x $131.68 for 1 Unit	$212.23	$212.23	$0.00
95869	(54.86/34.0376) x $63.12 for 1 Unit	$101.73	$0.00	$101.73
TOTAL		$1,029.99	$886.10	$143.90

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the specified services. As a result, the amount ordered is $143.90.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $143.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/11/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.